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ABSTRACT

Described is the Parenting Program for the Prevention of Child Abuse which employs home visits to upgrade home environments and to prevent physical abuse of children up to 6 years of age. The program is noted to focus on four major areas: psychological support of the parent; obtaining social services (including health services, educational programs, and financial assistance) that are needed; resolution of inner conflicts which contribute to the danger of child abuse; and parent education in the area of parenting skills. Also explained are factors considered when making referrals to the Parenting Program, specific evaluation and treatment functions, and training of therapists. (SBH)

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The Parenting Program

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The Parenting Program

The Parenting Program for the Prevention of Child Abuse is an activity of the Department of Psychiatry at Cleveland Metropolitan General Hospital. The hospital, which is part of the Cuyahoga County Hospital System, is one of the major teaching institutions of Case Western Reserve University, School of Medicine.

The Program was conceived out of experience with families with high potential for child abuse and neglect. This experience indicated that although these parents are designated by hospital staff as being in need of help, they themselves were often not troubled by the behaviors that were of concern to us. It was difficult and sometimes impossible to engage these patients in a therapeutic relationship which required them to keep regular appointments at the hospital. Since these parents could not come regularly to get the help we felt they needed, the solution was to reach out to them.

The Program employs the modality of frequent home visits in efforts to upgrade home environments and to prevent physical abuse of children up to six years of age. The Program was planned to focus on four major areas: 1) psychological support of the parent; 2) obtaining social services that are needed, including health services, educational programs and financial assistance; 3) resolution of inner conflicts which contribute to the danger of child abuse; 4) parent education in the area of parenting skills.

Referral to Parenting Program

Any community agency can make a referral to the Parenting Program. But since we are a small pilot project and need to limit numbers, we are striving first to integrate our services with others provided in our hospital. Major

sources of referral are:

1. Department of Pediatrics - mainly inpatient service.
2. Department of Social Service
3. Maternity and Infant Care Project which operates in several satellite health clinics.
4. Department of Psychiatry - Day, Evening and Satellite Outpatient Clinics

We evaluate any family thought by one of these agencies to be at risk of abuse or of seriously inadequate parenting. Although we have provided a set of guidelines for referrals, we do not have rigid requirements. Cases are usually referred following within-department staffings in which the consensus is that the family has problems in child rearing and needs intensive follow-up in the home. Some of the clues which lead to this consensus are:

1. Bonding failure, often occurring when the newborn must remain in the hospital Special Care Nursery when the mother is discharged.
2. Poor parent-child interaction.
3. Frequent emergency room visits with the child.
4. Removal of other children from the home.
5. Ambivalence toward the pregnancy; thoughts of having an abortion.
6. Low tolerance for stress from the baby; complaints judged by the staff to be unrealistic.

Other relevant factors considered when making referrals to the Parenting Program are:

1. Parental history of abuse/neglect.
2. Isolation of the family from a support system.
3. Unrealistic expectations of the child.

4. The "special child" physically or mentally handicapped, premature, the child who reminds parent of someone with whom they have bad associations, e.g. the boyfriend or husband who abandoned them.

Many high-risk families are identified when the child is admitted to a pediatrics ward. Therefore, cooperation with the pediatric inpatient service is essential. High risk families are also commonly identified through contact with health and social care-givers during pregnancy. There is no accusation of abuse when families are referred to the Parenting Program. It is viewed as a service to families having difficulties which interfere with child rearing. Case finding is fostered by continuing contact with the primary service-givers listed above and by attending meetings at which cases are discussed and assigned.

When families are accepted into our Program, they do not necessarily terminate work with other agencies. All work together, dividing tasks and increasing or decreasing involvement as seems appropriate. If a social worker from Cleveland Metropolitan General Hospital Social Service seeks our services for a family, we agree on a plan and the other worker remains available, but encourages the family to work more closely with the Parenting Program. Because our outreach capability and smaller caseload enable us to spend more time with each family, our program gets the very difficult cases.

In cases of suspected abuse, the Pediatrics Department staff may report the case to the County Welfare Department Protective Services for investigation to the Parenting Program for ongoing treatment. Because we come into the case independently and are based in the Department of Psychiatry we are often able to establish working relationships with patients which are not tarnished by participation in the diagnosis and reporting of abuse. When abuse has been reported, we cooperate with County workers, in order to avoid duplication and provide the best service to the patient.

Program Functions

Evaluation and Treatment: Introduction to the Parenting Program includes a clinical evaluation and administration of the Minnesota Multiphasic Personality Inventory. Following evaluation, a treatment plan is evolved and an agreement is established with the patient concerning its goals. Goals and methods are tailored to the individual's needs. If, for example, a mother has been managing her home and children adequately until she was abandoned by her spouse and is now experiencing depression, acting-out and anger against her spouse, child or children, the goal of treatment would focus on resolving her feelings about her loss, helping her to adjust and make a new life and on working through underlying conflicts which may be interfering with this adjustment. If on the other hand, the mother is now separated from a husband who had taken all the responsibility for home management and she has never learned to take responsibility for shopping, cleaning and paying bills, the goal of her treatment must include helping her to accept and fulfill these responsibilities as well as helping her to adjust to her loss.

The parents referred to our Program vary tremendously in ability to manage their lives, as well as in the dynamics of their child-rearing problems. When the parents have difficulty managing everyday affairs, improvement in that area often helps the child rearing immensely. But sometimes the parenting is the major problem. Often there is a target child on whom negative feelings are focused. The child may be seen as being like the grandparent who abused or did not love the potentially abusing parent; or the child may be identified with the parent's own "bad self". Work with each parent must be directed to that individual's problem.

There are some patients with whom we do not try to work. These include parents with less than borderline intelligence and psychotic patients (unless well-controlled by medication). We try to avoid becoming involved with schizophrenics since we do not feel our staff is equipped to deal with them. The patient who is addicted to alcohol and/or other drugs is also ordinarily considered to require a special program focused on those problems before our Program can be useful.

Although a very few patients are able to come to the hospital and are seen as outpatients here, nearly all are seen in their own homes by psychology assistants, specially trained college graduates who are supervised by professional psychologists. All the patients are seen from 1 to 4 times a week. We analyze our services into the following major categories:

1. Supportive therapy
2. Obtaining concrete services as needed
3. Insight - oriented treatment of inner conflicts which contribute to family problems.
4. Parent guidance.

Since our population is composed largely of inner city poor people, a high proportion are one-parent homes. For this reason we work most often with the mothers. This is not to say that she is the only potential abuser in the family, but only that she is the most available person.

The major focus is on treatment of the patient's emotional problems. Patients are accepted into the Parenting Program in the expectation that supportive therapy will meet some of their emotional needs, improving their ability to cope, and preventing their lives from deteriorating to the point where the potentially abusive parent loses control and actually hurts the child. Special

attention is given to helping parents resolve their own conflicts and see the child as a separate individual rather than as a representation of the bad part of themselves or someone else. Other important aspects of treatment focus on making patients aware of feelings, on separating feeling from action, and on educating the parents in reasonable expectations of children of various ages and in alternatives to corporal punishment for training and disciplining children.

Another way in which the Parenting Program helps patients to avoid overwhelming stress is to help them to obtain the social services, e.g., welfare benefits, preschools, health care and family planning which they need.

The ability of these parents to manage their lives is so marginal that crises develop frequently, causing failure of coping mechanisms and defenses. An immediate corollary to this breakdown is an increased danger that the patients will abuse their children. Therefore, while working on the therapy the workers must keep a sharp eye on the overall situation and be prepared to intervene should a crisis develop. When this occurs, they must be able to switch attention to the crisis and help the patient to handle it before returning to her ongoing intrapsychic problems.

Training of Therapists

Our patients vary tremendously in coping ability and problems presented. The staff has had to learn to deal with all of these problems and they need special skills for each kind of problem. They need to know principles of child development, child rearing and parent guidance, in addition to techniques of therapy with adults. Since they must deal with environmental problems, the psychology assistants also need specific information on community resources available to alleviate environmental stresses.

In order to perform their complex tasks well, the psychology assistants require much specific training. Providing this training is a major function of the Parenting Program and the psychology assistants spend 1½ - 2 hours per week in didactic training in addition to supervision and preparation time. Basic elements of this training include the following:

1. Reading and seminars in child development, personality theory, psychopathology and methods of therapy.
2. Interviewing and therapy skills.
3. Consultation in the use of community resources.
4. Intensive supervision of work with individual patients.
5. Participation in all continuing education programs of the Department of Psychiatry.

Additional services are obtained as necessary. Some of those which the Parenting Program helps the patient to find are:

1. Psychiatric evaluation for psychoactive medication from psychiatrists in our Department.
2. Home visits from a nurse if pediatric care is indicated and the parent is uncooperative.
3. Help in obtaining medical follow-up for the parent and the children.
4. Referral for day care centers or preschools for children.
5. Referral to other agencies for food stamps, welfare, etc.
6. Contact with Parent Education and Infant Stimulation classes and with special playroom teachers who teach the parents about how to teach and play with their children.
7. Assistance in efforts to further their own education.
8. Crisis care for the children.

Sometimes the home situation is so hazardous that the staff feels obliged to inform the Welfare Department, always discussing the plan with the parent beforehand.

The Parenting Program has been well received in its year and a half of operation, and has been successful in averting danger to a number of children. But it has made an even more valuable contribution by increasing our knowledge and skill in dealing with this problem. We are still learning daily to sharpen our skills so that our interventions will have increased effectiveness. We are looking for new ways to work with these families. We have recently started a therapy group for mothers during which their children are provided with expert care. We would like to have our own day-care program for some of the families.

It is clear that high-risk families vary greatly in education, socioeconomic class and psychiatric problems. All need one or more of our four types of services: supportive therapy, concrete services, insight therapy and parent guidance. The people referred to our Program usually require massive inputs of support and concrete services before they can work on inner conflicts or parent guidance. With high-risk families in other educational and socioeconomic groups, the same elements of treatment are needed, but the emphasis is different. There may be little or no need for concrete services and the insight therapy may be a much larger factor. Many times, when the inner conflicts are worked through, the parent is able to put into effect the very adequate parenting skills he or she already had, and parent guidance becomes minimal.

Thus, although high-risk families occur in all classes of society, the ingredients of treatment remain the same, although the proportions vary considerably.